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ABSTRACT

The paper presents an outline for the development of a community mental health program based on assessment of a first grade population in an urban Negro neighborhood and involving a strategy that places primary emphasis on establishing ongoing community sanction and participation in policy-making. The strategy included the development of a community-wide system for the periodic assessment of specific subpopulations in the community; one that would give basic information for program development. The intervention program for a total population was based on the assessment of both qualitative and quantitative characteristics of need, while evaluation of the program involved periodic reassessment of needs in the total population. The intervention program was refined in light of the kinds and quantity of impact achieved by the program. Results of the study indicate that gaining and maintaining community sanction through citizen participation at both the policy-making and operational levels of human services is critical for the success of community wide programs. (Author/SES)

STRATEGIES IN URBAN COMMUNITY MENTAL HEALTH

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The entire school mental health program of study and intervention has depended on the strong support and active collaboration of the faculties of the twelve Woodlawn elementary schools. This report is one of the products of this collaboration. The authors and the staff of the Woodlawn Mental Health Center are grateful to the faculties for their help in this partnership.

The direction of the first-grade intervention program and the training of school and mental health staff associated with this program were the primary responsibilities of Dr. Sheldon K. Schiff until June, 1970. Dr. Schiff and the senior author shared responsibility as Co-Directors of the Center until April, 1970. Mrs. Jeannette Branch, formerly Chief of Children's Mental Health Services at the Center, assumed the position of Director July 1, 1970. The third member of the original team of Co-Directors, Dr. Edward H. Futterman, left the Center in 1965. Dr. Futterman shared with us the trials and problems of the Center's formative period and made an important contribution to its development.

The staff of the Woodlawn Mental Health Center responsible for clinical services to the community while this research was being conducted has been and remains crucial in the development and evolution of the Center. The authors would like to acknowledge the contribution made by Mrs. Doris Van Pelt, M.A., Staff Psychologist, Woodlawn Mental Health Center, in the analyses of these data. For help in the organization and clarification of this paper, we are indebted to our publication unit and especially to Mrs. Loretta Hardiman, Editor.

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In the United States, the design and implementation of mental health services have historically limited access to service to two specific groups of people. The first, severely disturbed individuals, have received help mostly through the state hospital system, one of the oldest socialized medical programs in this country. The greater percentage of these individuals have been poor, partly because the limited financial resources of the poor precluded other alternatives. The second group has included mainly those people able to afford private, individual out-patient care--the upper middle and upper class sectors of society (Davidson, 1967; Hollingshead and Redlich, 1958).

This state of affairs has left a population vastly larger than either of the aforementioned to suffer a dearth of mental health services. As the plight of these people has worsened, particularly in our urban centers, both the American public and mental health professionals have begun to exert pressure for innovations in mental health practice. Since the early 1950's and on through the 1960's there has been a groundswell of public support to do something about this prevailing gap.

In response to growing public awareness, mental health professionals are struggling with the challenge to develop a wider diversity of services which emphasize the importance of the social system to the individual's sense of identity and self-esteem. In some instances this has led to community-based programs located in

or near the social contexts in which people's troubles occur. In the process of determining priorities and gaining ongoing sanction for programs, some mental health professionals have also assumed more initiative in developing links with local community citizens.

In our view intervention should be intimately related to the processes which occur in social contexts in the community. Thus the targets of intervention are not restricted to individuals or families as in the case of the clinic setting. On the contrary, any aspect of the social field processes related to the individual's sense of well-being can be subject to intervention. In school the classroom is a major social field and the teacher, the peer group, the family, the administration of the school, or even the curriculum can receive the attention of the intervention process.

Such a social system view of intervention requires, however, more than mental health skills. Other health, education, and welfare workers, who are under increasing duress because of the general failure to meet human needs, may also ascribe to such a view. Indeed our own experience, based on systematic studies and clinical impressions, raises the question as to whether our focus ought to be on mental health as a speciality or on an integrated human service system that seeks to approach mental health through institutional processes which are more conciously and purposefully concerned with the breadth of human need.

This chapter will examine this and other issues that have come to our attention during our years of work in a mental health program that was begun in 1963 in Woodlawn, an urban Negro neighborhood on

the south side of Chicago. The 1960 U. S. Census Bureau figures, gathered four years prior to the start of our work in Woodlawn, set the population of this community at 81,000. Our base has been the Woodlawn Mental Health Center, a facility of the City of Chicago Board of Health. Additional funds have been granted by the State of Illinois Department of Mental Health, with research and training functions being supported also by the University of Chicago Department of Psychiatry.

This discussion of the Center's program development reflects our thinking during the years when the notion of independent community-based mental health services was still to us a viable idea. What was then the most avant-garde conception of mental health has evolved with startling speed. Many mental health professionals, including ourselves, have moved over the last several years from the concept of mental health centers to comprehensive health centers and from there to serious consideration of the neighborhood human service system (Daniels, 1969).

The Contract with the Community

In 1963 the staff began its work in Woodlawn with the strong belief that community mental health needed new strategies operating from new institutional bases that would provide avenues for reaching people in need, and facilitate effective contribution by the community. One of the major problems facing health, education and welfare professionals is the development of ways of relating more closely with the communities they serve. Agencies need to move closer to the social contexts in the neighborhood. To do this the neighborhood and the agency must negotiate a contract in which the citizens exercise their role by sanctioning agency involvement in

the neighborhood, by collaborating with the agency in priority setting, and in planning and participating in the carrying out of services.

The Neighborhood Agency Council Model

Several models for local community participation have been developed over the years. One of the oldest is the neighborhood agency council. The idea was to bring together the variety of agency professionals in a community to establish common goals, collaborative procedures and coordinated services. Occasionally one or two citizens from the neighborhood were invited to join the council and provide some representation for the consumers of the services offered by the professionals. In smaller rural communities where agency professionals live in and identify with their community, this model may be more effective; in the urban community, however, the inclusion of a few citizens in the agency organizational structure generally produced negligible results. The citizens most often felt excluded from the basic agency organizational structure and had no structure of their own within which to operate. A very basic lack of this model was the absence of any real definition of the powers of the consumer in policy-making.

The Retail Store Model

Another attempt to bring agency and community closer together is the retail store model. In recent years some programs have been located in store-front facilities on the main streets of the neighborhood they serve, presumably to bring services within easy, convenient reach of the citizens. Nonprofessional community people may serve as counselors, group therapists or in other roles designed

to involve the community in the program. This model offers no formal or informal contract between the community and the agency. Such a strategy suggests that the mental health needs of the community may be defined by determining the categories of need in which the most demands for help occur. When programs are planned on this basis, the community is left little opportunity to participate directly in the process. If the citizens do not like the selection of services offered or feel a need in an area where no services are provided, the likely alternatives are (1) not to use the services or (2) to protest through demonstration or picketing. In the seventies, with the unrest growing out of the concern over citizen participation in agency policy-making, the lack of a structure for ongoing negotiations with the community makes it quite improbable that professionals could gain access to the main social fields of the community for programs of prevention.

The Volunteer Board

Agencies which utilize the volunteer board model must rely on advertising in the neighborhood that any citizens interested in taking part in planning of services should come to community meetings held by the agency. Often no criteria of membership are defined and no serious investigation is made to determine whether the various citizen groups in the community are represented. Such boards are often constructed by agency professionals who generally have not been successful in attempts to find and engage with community leadership. The citizens who attend may or may not have the right to speak for others in the

community, and large groups within the neighborhood may vigorously contest the validity of such a board.

The Elected Community Board

From time to time citizen boards have been elected by majority vote. This method has great appeal to middle class professionals who often feel the election is an essential characteristic of the democratic process. In large urban areas where there is a strong political machine, such a method may give tremendous advantage to machine candidates, thus eliminating the neighborhood independent leadership. The experience with this kind of board in Philadelphia and elsewhere suggests also that only small percentages of citizens actually vote in such elections (Clark and Hopkins, 1968).

A Community Board Composed of Citizen Organization Leaders

The board composed of community organization leaders, while not free of problems, is the model we have found useful in supporting our efforts in community mental health programming in Woodlawn. This model recognizes the already-existing leadership of community organizations. Each community organization delegates a community representative who is empowered to represent that organization's view on the board. In our view this method is most likely to afford representation of the broadest range of community aspirations and opinions.

The Community Board in Woodlawn. The evolution of the Woodlawn Mental Health Center board began in 1963 after a commitment of support had been obtained from the City of Chicago, the State of Illinois Department of Mental Health, and the University of Illinois Department of Psychiatry. The three psychiatrists[1] who would become the Center's Co-Directors approached Woodlawn's community

leaders to discuss the possibility of coming to Woodlawn to establish, with the community, a community mental health center. We made it clear from the beginning that we would not come to Woodlawn unless they, as the community's established leadership, offered their support.

Considerable discussion ensued. Very specific questions of trust were raised by the leadership, especially the question of why three white doctors wanted to become involved with the Woodlawn community. After a good many reservations had been voiced about the placing of a community mental health center in their neighborhood, these citizen leaders finally agreed to provide the support we needed to begin our work.

A watchdog committee was appointed by The Woodlawn Organization, an especially strong, influential confederation of smaller political and social groups in the community. We welcomed the watchdog committee since it gave us our first structure through which we could engage with the community. In the many conversations we had with members of the committee and other community organization leaders, we were able to emphasize our belief that we needed community support for any programming we might undertake, and that as professionals our first commitment was one of service to the community.

The watchdog committee compiled a list of Woodlawn's community organizations, and representatives from these organizations joined together to form an advisory board. The major problem confronting the new board was defining its powers. This issue revolved around the board's role in choosing program priorities in dialog with the Center staff; the board's collaboration in planning programs; the board's communication of the community's concerns to the staff; and the role of the board in providing community sanction for programs (Kellam and Schiff, 1968).

Choosing the first program that the Center would develop was tremendously important in defining the role of the board on one hand and that of the staff on the other. While the staff was a source of technical information, both the board and the staff realized that program priorities is an issue to be decided by the community. Whether a program for children is more or less important than one for acutely disturbed adults is a decision most rightfully made by the community citizens--even though the technical information offered by the staff and the availability of resources must be taken into account. Social values, then, become a primary determinant in this kind of decision-making process, and when a service facility is supported by a board comprised of various community organization leaders, the advantage is clear. Board members can return to their own organizations for open discussion of not only priorities but proposed program plans. Thus any necessary modification and, in fact, a kind of formalized community approval can take place before programs actually begin.

After lengthy discussion with the staff and the community, the Woodlawn Mental Health Center board finally made the decision to develop a program of prevention and early treatment for the community's first-grade children. Board members continued to attend various community organization meetings and meetings of parents and teachers to explain the program, answer questions, and enlist full support for the program. In many cases, board members were vigorous, effective troubleshooters when issues arose in the schools or in the community that threatened the program's survival. There is little doubt that their

continuing efforts were fundamental to the introduction and ongoing operation of the program in Woodlawn's twelve elementary schools.

The community board has been the stable foundation on which programs have been built at the Woodlawn Mental Health Center. There has been a distinct evolution of the board's relationship to the staff, to the organizations from which the board members originally came as representatives, and the community at large. Though the board began as an informal advisory board, over time a constitution and by-laws were developed, board leadership was assumed by an elected chairman, and board members became increasingly involved in the intimate workings of the Center itself.

The problems that remain for the board to consider and resolve have to do with the degree of strictness with which staff and board should be separate and have separate roles; how to maintain a board membership which truly reflects the diversity of community populations to be served; and the degree of involvement the board should have in the internal functioning of the Center. These problems are no less critical now that we are beginning to be concerned with planning new comprehensive neighborhood human service systems than when we considered community mental health the function of an independent agency.

Once the community board is established, the next step is to define a strategy for community-wide mental health programming. The strategy that was implemented in Woodlawn may be simply depicted as consisting of the following steps:

(1) selection of total subpopulations in the community for which programming is to be planned after sufficient community

involvement has occurred;

(2) selection and development of methods for conducting periodic community-wide assessment of the mental health needs of the specific subpopulations for which programs are to be designed;

(3) following the initial assessment of needs, development of intervention programs which range from direct services in strategically selected sites in the community to programs aimed at strategic aspects of the social system;

(4) re-assessment of mental health needs following programming, with adequate care to provide the control populations necessary for systematic, specific measures of impact; and

(5) re-development of programs in the light of clinical experience and measured impact.

In the long-run, such measures of need and impact may present opportunities for combined programming across professional disciplines, with a number of different professional agencies using the same measures for planning and evaluation.

As we briefly describe the experience with this strategy as it was applied to the Woodlawn School Mental Health Program of Prevention and Early Treatment, it should be remembered that although this program was based on measures of mental health need and was essentially a mental health program carried out in collaboration with the schools, it did not achieve the degree of agency synthesis we have suggested as optimum. This appears to be part of the work which now confronts us.

Assessing Mental Health Need

Our strategy required that community mental health programming deal with specific definable subpopulations of a total community

whose boundaries are clearly delineated. Woodlawn's boundaries have been precise and stable for a number of years so this criterion was easily met. Our collaboration with the board on the issue of setting priorities had early produced a commitment to develop community-wide mental health services for young children. First graders are the youngest total subpopulation accessible in the community, i.e., the youngest age other than birth at which names and addresses are known. In addition, first grade marks a point of major transition in a child's life course--his first legal step out of the family on his own. Thus the strategic social field in which to develop community-wide programs for first graders appeared to be the school--specifically the first-grade classroom.

What is Mental Health?

In several ways, criteria for mental health are more important to the program developer working in the community than for the professional working in the traditional clinic. In the latter case, it is the patient who finds his way to the clinic, and this in itself is a primary selection criterion, however inadequate. As a result, this kind of clinic is concerned primarily with the people who come for help rather than the entire population in need in the community. The program developer in the community, however, must be concerned with the total population; therefore he must define selection criteria more specifically than the traditional self-selection method allows.

The Woodlawn first-grade program required a specific, operative definition of mental health which would permit us to make qualitative and quantitative measures of mental health. The aim to develop a

community-wide prevention program added a still more complex issue to this already knotty problem since the preconditions--whether in the system, the child or both--of later emotional difficulties needed also to be identified.

Even though in recent years traditional clinics have tended to include a few family members or significant others in their consideration of a patient's problems, community programs must be based on the characteristics of the social system as well as important characteristics of the individual person. In fact, help may be most strategically directed at the social system, or particular aspects of it, in addition to or instead of the person in need.

Generally, mental health clinicians and investigators seeking definitions of mental health or mental disorder have approached the task using one or both of two basic views as sources: first, that of social adaptation, social mastery, or the adequate functioning of an individual in a social role; and second, the sense of well-being, self-esteem or self-confidence of the individual. Upon superficial examination, these two views may seem contradictory. If an individual is socially well-adapted, can we assume he is experiencing a sense of well-being? Indeed is adequate social performance even compatible with a sense of well-being when social performance requires a degree of conformity and restraint?

If we consider the nature of these two dimensions of mental health, the social adaptive view implies that mental health involves a degree of acceptance by society of one's behavior, i.e., adequate performance in some sense equals good mental health. The second view, a sense of personal well-being, suggests quite a different source of

definition, namely the individual himself. The societal view has a legal and social power which cannot be denied and certainly represents an important contribution to the definition of mental health. The individual view, on the other hand, must be considered equally important. Empirical studies of the relationship between these two dimensions are vital to the general problem of defining mental health. This need has been cited in an article by Blum in which he states the value of such research and carefully analyzes the problem of defining criteria of mental health and illness (1962). On the basis of this discussion it could be argued that such research is fundamental to the development of community-wide programs of prevention and early treatment, and we will discuss several such studies later in this chapter.

When intervention is a goal of program planning as it was in Woodlawn, the social adaptive view is no more likely to lead to effective programming than the individual patient-oriented view; alone, neither facilitates systematic intervention. In combination, however, these two major areas of criteria should allow intervention to be conceived of as directed primarily at the social system--a view which allows us to consider the individual, as well as his total social and interpersonal network, as potential areas in which help might be given.

In approaching the assessment of the social adaptational status of first graders or any other subpopulation in the community, several background concepts are helpful. All the individuals in a community are passing through various stages of life. Each stage of life is

intimately related to three or four basic social fields such as the family, the classroom, the peer group, and so on. In each social field a natural rating process is carried out by the natural raters. The parents in the family, the teacher in the classroom, the foreman on the job and one's social peers are all examples of natural raters.

In a sense, natural raters function to transmit to the individual, through a variety of social institutions, certain goals of the social system. As part of this process, the natural raters in a social field define the tasks each individual must perform in pursuit of system goals. In addition, the natural raters judge each individual's performance of these tasks, either formally or informally. One's teacher and one's foreman make formal judgements. The judgement of peers or parents is usually informal but nevertheless quite important. These judgements represent the social system's view of the social adaptational status of the individual.

In accord with these background concepts, we proceeded to examine the natural rating process that goes on in the first-grade classroom. We first determined the tasks required of the children in the social system of the classroom. We then developed procedures to obtain systematic ratings of how well each child was performing in the role of student in the judgement of the natural raters (Kellam and Schiff, 1967).

Assessing the Child's Adaptational Status

The first-grade teachers in Woodlawn's twelve elementary schools (nine public and three parochial) were contacted through the District Superintendent, the archdiocese office, and each of twelve principals. The teachers were asked what major tasks first-grade children face when they enter the new social field of the classroom. On the basis of the teacher responses, we were able to construct five scales representing the major social tasks required of the child by the system. A sixth scale was added relating to the overall adaptation of each child to first grade. These six scales were:

1. Social Contact
2. Authority Acceptance
3. Maturation
4. Cognitive Achievement
5. Concentration
6. Global Adaptation

The scales were constructed so that they could be used to assess various aspects of each child's social adaptation to the role of student. Students were to be rated by their teachers on a four-point scale with 0 being the only adapting rating and 1 through 3 representing mild to severe maladaptation. Assessment was planned to take place in standardized interviews with the child's teacher several times in first grade and periodically thereafter. This procedure was called Teacher's Observation of Classroom Adaptation (TOCA). In the context of the life course-social field concept, the teacher is the natural rater of the child in the classroom and thus provides the system's view of his social adaptation status as a student. As our

educational system is constructed, the child must succeed in the view of his teacher if he is to achieve a good school record. She is the legally appointed judge of her students despite the fact that she may be sensitive or insensitive, fair or unfair in her assessment.

In the fall of 1964, soon after the development of the assessment instrument, the first ratings were made of all the first-grade children in Woodlawn. The teacher interview, conducted by a member of the Center staff, was characterized by an open-ended, yet structured format. Initial conversation was devoted to any concerns the teacher might have about the program, her students, her school or whatever. Then the interviewer recorded the teacher's ratings of each child in her class.[2]

Validation procedures were carried out to see if these numbers we called ratings meant anything. A series of comparisons were made of various a priori characteristics of the child. For example, children who had had kindergarten were compared to children who had not had kindergarten; girls were compared to boys; children who had changed schools within Woodlawn between kindergarten and first grade were compared to those who had not; and children who were repeating first grade were compared to those who had attended kindergarten the previous year.

The comparisons indicated that our ratings were valid gross measures of social adaptation. Children who had not had kindergarten appeared to their teachers to be more shy and more globally maladapted. Boys were more maladapted than girls on all scales except Social Contact. Children who had changed schools between kindergarten and first

grade were rated more maladapting on all scales except Social Contact.

Of most interest is the proportion of children who each year were having difficulty in one or another of the social adaptation categories. Table 1 contains the results, for control schools only early in first grade of these assessments over the course of four years for each scale. (In order to provide a group against which to evaluate the intervention program, six of the twelve Woodlawn schools were designated as control schools. See discussion on page 22). Consistency in the prevalence rates of each adaptational scale from year to year is indicated by the narrow ranges across the four years. The number of children having trouble was a strong factor in the design of the intervention program.

Over the four year period covered by Table 1, about two-thirds of Woodlawn children were assessed as having mild, moderate or severe problems in their early efforts to accomplish one or another of these tasks. When we assessed these children's social adaptational status again in third grade, we found that early mastery in school was significantly. associated with the child's future adaptation. These data were useful as we sought to investigate the children's sense of well-being, a major criterion of the concept of mental health we are considering.

TABLE 1

TEACHERS' OBSERVATIONS OF CLASSROOM ADAPTATION MADE EARLY IN FIRST GRADE - CONTROL CHILDREN ONLY

Percentage Ranges Across Four Years*

SCALES OF ADAPTATION (ranked by percent adapting)**	0 = Adapting within minimal limits	1 = Mildly maladapting	2+3 = Moderately or severely maladapting
Authority Acceptance	71.4 - 75.3	10.7 - 14.1	10.6 - 18.0
Social Contact	68.3 - 73.7	14.6 - 18.0	8.3 - 15.8
Concentration	57.6 - 64.0	16.7 - 22.0	14.0 - 25.6
Maturation	56.8 - 63.0	18.3 - 21.6	15.7 - 24.9
Cognitive Achievement	52.0 - 58.1	20.9 - 28.5	15.0 - 22.6
Global Adaptation	31.1 - 38.8	36.5 - 42.8	21.3 - 32.3

*Populations for these studies include all of the children in the six Woodlawn control schools early in first grade in 1964 (N=944), in 1965 (N=863), in 1966 (N=737), and in 1967 (N=732). The total number of children enrolled in first grade decreased each year in intervention schools as well as in control schools.

**The rank order of these scales for percent adapting was the same in each of the four years.

Assessing the Child's Sense of Well-Being

We devised several procedures with which to assess each child's sense of well-being. One procedure involved the direct observation by clinicians of the children in a standardized play setting; in another the mother's observations were used to derive a measure of the child's psychiatric symptom status; in a third, the child was asked to rate himself on two aspects of his sense of well-being, sadness and nervousness. Each of these methods was kept independent from the others so that we could study their interrelationships.

While we refer to these methods as ways of measuring symptoms, they do not fully warrant such an assumption. We use the term symptom provisionally until sufficient empirical research has been done to establish whether what we measure should indeed be called symptoms. In addition to that caveat, no one of the methods should be thought of as an adequate clinical screening method of psychiatrically disturbed children. They are considered separately here for purposes of study.

In the direct clinical observation (DCO), teams of clinicians made symptom ratings based on traditional categories of psychiatric symptomatology. They observed a 50 percent random sample of Woodlawn first graders in which there were equal numbers of boys and girls. As shown in Table 2, children rated symptomatic by clinicians using the DCO procedure numbered far fewer than those who were rated as socially maladapting by their teachers (refer to Table 1). The frequency rates are fairly consistent across the two populations that were studied, the 1964-65 and the 1966-67 first graders. Five different

TABLE 2

PERCENTAGE OF CHILDREN RATED SYMPTOMATIC

BY DIRECT CLINICAL OBSERVATION

SYMPTOMS	Early in First Grade		End of First Grade		Third Grade
	1964-65 N=1000	1966-67 N=1080	1964-65 N=1000	1966-67 N=1120	1964-65 N=1350
Flatness of Affect	1.0	1.1	0.4	0.9	1.3
Depression	1.5	0.6	1.2	0.8	0.4
Anxiety	2.8	2.4	3.4	1.8	0.8
Hyperkinesis	1.7	0.7	1.3	1.5	0.9
Bizarre Behavior	2.9	1.3	2.4	1.8	1.0
Global	6.9	4.6	6.4	4.9	3.9

community-wide assessments were made, one early in first grade for both populations, one at the end of first grade for both populations, and one at the end of third grade for the 1964-65 population.

Although the results were consistent from one population to the next when the same procedure was employed, the percentage of symptomatic children varied widely from procedure to procedure. The results of the mother's symptom inventory (MSI) illustrates this point. The inventory consisted of 38 behaviors often considered symptoms by clinicians (Lapouse and Monk, 1958). It was administered to two large populations of mothers of first-grade children. The sampling procedure for these two interviews is described on page 26.

In Table 3, the behaviors are arranged under thirteen general category headings. The behaviors were suggested by the work of Conners who originally validated most of them for Negro children of the same age living in a neighborhood similar to Woodlawn (1967 and 1970). Table 3 indicates the percentage of children rated by their mothers as "not at all" exhibiting these behaviors and the percentage rated as exhibiting these behaviors "pretty much" or "very much."

The frequency rates are again remarkably consistent from the 1964-65 population to the 1966-67 population. However, the percentage of children who were rated as exhibiting each behavior ranges broadly although generally the frequencies are much higher than those obtained using the DCO procedure.

In a third procedure, psychiatric symptoms were assessed on the basis of self-ratings by third-grade children who were administered an instrument called the "How I Feel." The study population consisted of

TABLE 3

THE FREQUENCY OF SYMPTOMS AMONG FIRST-GRADE CHILDREN AS REPORTED BY MOTHERS
1964-65* AND 1966-67** CONTROL SCHOOL CHILDREN ONLY

MOTHER SYMPTOM INVENTORY ITEMS GROUPED BY SYMPTOM CLUSTERS	Percentage of Children Reported Having Symptoms "NOT AT ALL"		Percentage of Children Reported Having Symptoms "PRETTY MUCH" and "VERY MUCH"	
	1964-65	1966-67	1964-65	1966-67
EATING PROBLEMS				
Picky and finicky about food	38.55	37.10	23.91	27.42
Underweight	73.41	69.17	5.27	5.88
Overweight	90.46	91.91	1.45	1.73
TROUBLE WITH FEELINGS				
Lets himself get pushed around by other children	47.30	51.43	16.22	15.89
Keeps anger to himself	66.85	72.48	7.12	6.84
CHILDISH OR IMMATURE				
Clings to parents or other adults	61.26	64.04	12.36	11.63
Sucks thumb	82.24	86.51	10.66	9.36
FEARS				
Afraid of being alone	61.04	60.44	10.90	12.52
Afraid of new situations	73.70	73.48	2.19	3.23
Afraid to go to school	94.59	92.47	1.08	1.80
Afraid of people	91.53	89.29	0.54	1.82
TOILET PROBLEMS				
Wets bed	85.40	84.89	8.54	8.82
Runs to bathroom constantly	76.78	80.96	6.29	4.80
Has had accidents with bowel movements in the past year	88.22	89.21	2.46	2.16
Wets self during the day	95.26	95.84	1.12	2.35
NERVOUS HABITS				
Picks at things such as hair, clothes, etc.	71.04	73.35	6.56	7.52
Bites or picks nails	76.58	78.46	6.06	6.82
Chews on clothing, etc.	84.47	84.74	3.54	4.66
SAD AND WORRIED				
Cries and sobs for unexplained reasons	76.22	79.75	7.57	5.02
Worries about illness and death	80.93	84.20	4.63	5.20
Looks sad	70.30	74.69	3.00	3.77

MOTHER SYMPTOM INVENTORY ITEMS GROUPED BY SYMPTOM CLUSTERS	Percentage of Children Reported Having Symptoms "NOT AT ALL"		Percentage of Children Reported Having Symptoms "PRETTY MUCH" and "VERY MUCH"	
	1964-65	1966-67	1964-65	1966-67
COMPLAINS OF SYMPTOMS EVEN WHEN DOCTOR FINDS NOTHING WRONG				
Stomach-aches	56.87	54.68	6.05	6.84
Headaches	69.21	66.43	4.90	4.46
Aches and pains	82.97	84.05	2.75	1.62
Loose bowels	87.36	87.34	1.92	1.24
Vomiting	84.25	82.94	1.66	1.08
SPEECH PROBLEMS				
Doesn't speak clearly other than stuttering	74.10	76.52	5.79	5.56
Stutters	85.05	88.63	2.45	2.52
SEX				
Plays with own sex organs	85.95	85.38	4.95	6.24
Involved in sex play with other children	92.33	93.06	2.19	1.95
MUSCULAR TENSION				
Twitches and jerks, etc.	83.78	89.39	4.59	1.62
Muscles get stiff and rigid	91.83	93.51	1.63	1.26
Body shakes	95.68	96.04	0.81	1.08
SLEEP PROBLEMS				
Restless or awakens at night	81.59	78.84	3.57	4.34
Has nightmares	83.20	78.32	2.44	2.55
BIZARRE BEHAVIOR				
Says wierd, odd or strange things	79.61	80.60	3.58	3.03
Looks stony-faced	86.92	84.79	1.36	1.43
Has weird, odd or strange movements or looks	89.86	89.84	0.54	1.07

*Children in control schools from early to end of year (N=370).

**Children in control schools from mid-year to end of year (N=562).

groups of 20 children chosen randomly from the total class population of each of 44 third-grade classrooms in Woodlawn. The total was 752 children. Table 4 shows the percentage of children who indicated that they felt nervous or sad, and again we observe the distinctiveness of these frequency rates from those of the other procedures. One must remember, however, that "How I Feel" was administered to third graders, not first graders.

As we commented earlier, it is also important to remember the conceptual problem involved in interpreting ratings of all these kinds of behaviors as psychiatric symptoms. Can a child who rates himself as sad be considered symptomatic on the basis of such a rating? Do such behaviors as being picky and finicky about food have the same meaning as, say, ratings of anxiety by a clinician? Obviously we are discussing a broad variety of behaviors, some of which have been related empirically to being a psychiatric patient while others have a tradition among clinicians of being considered symptoms. And, of course, one of the basic reasons for the problems in defining a symptom is that we are still struggling with the question of what psychopathology is. This last question requires that more empirical research be done into the interrelationships among such symptom measures as are now available, including those involving more intensive psychiatric examination of individuals. It requires also that empirical research be done into the relationships between psychiatric symptoms--measured in a variety of ways--and the process of social adaptation.

In this regard our research appeared to be simpler when we were

TABLE 4

FREQUENCY DISTRIBUTION BY PERCENTAGE OF SELF-RATINGS MADE BY THIRD GRADE CHILDREN ON TWO HOW I FEEL QUESTIONS

How I Feel Questions	Almost not at all	A little	Pretty much	A lot	N*
I Feel Nervous	31.8	36.3	16.8	.2	752
I Feel Sad	35.6	34.5	14.9	14.9	750

The population consisted of groups of 20 children comprised half of girls and half of boys who had been randomly selected from each of the third-grade classrooms in the twelve Woodlawn schools.

*The N's are different because two of the children did not respond to the "I feel sad" question.

concerned with studying the 1964-65 first graders by the DCO procedure than it does now that we have had a chance to replicate these studies with the 1966-67 first graders. The results of concurrent studies carried out on the 1964-65 population of first graders indicated a significant relationship between being rated symptomatic by DCO and being rated as maladapting in the classroom on the Social Contact and Global scales at the beginning of the year, and on the Authority Acceptance, Concentration, and Global scales at the end of the year.

If we look at this relationship longitudinally, children in the 1964-65 population who had difficulty mastering the social adaptational tasks of first grade early in the year were also more likely to be rated symptomatic at the end of the year than were children who began first grade adapting. However, in replicating these studies we have found this relationship to be more complex than we had imagined. The results of the early DCO-TOCA concurrent studies in 1966-67 were very similar to those of the 1964-65 study, in that children found to be symptomatic early in first grade were having difficulty in the areas of social contact and maturation. On the other hand, in the end-of-year study, the concurrent relationship disappeared. We found no relationship between being assessed as symptomatic by a clinician and being assessed as maladapting by a teacher at that time--and just as unfortunately, no clear explanation as to why the relationship disappeared. The Mother Symptom Inventory and the How I Feel , however, do reveal significant relationships between social maladaptation and being symptomatic. We are still analyzing these data in hopes of further clarifying this relationship.

Even though the relationship between symptoms and social adaptation appears to be a very complex one, where it occurs--at least with the procedures we have used and the populations we have studied--this relationship is almost always in one direction. Symptoms are associated with social maladaptation, not social adaptation. We can say, then, that thus far there appears to be a relationship between psychiatric symptoms and the failure to adapt socially, though this relationship still needs to be clarified by using other methods of assessing symptoms, other study populations at other stages of life and by study of other communities.

The Results of Assessment as a Basis for Planning Intervention

Early results indicated that large numbers of first-grade children were maladapting, and that these children were more likely to be symptomatic than were adapting children. The population of maladapting children thus appeared to be a strategic population for intervention.

Accordingly, Woodlawn's twelve elementary schools were divided into two matched groups on the basis of the prevalence of maladaptation among the first-grade children in each school and other criteria such as the financial resources of the families and the size of the enrollment in each school. By flipping a coin, one of these matched groups was designated control schools and the other intervention schools. While systematic, periodic assessment was to be carried out in all twelve schools, only the six intervention schools were to receive the intervention program in first grade.

This plan would enable us to compare various assessments of children in the intervention program with those of children in the nonprogram control schools.

Evaluating a Program of Prevention and Early Treatment

The intervention program was the result of the decision by the Center's board to ask the staff to program for first graders. Program design was based on the life course-social field concept described earlier and the results of early assessment. The first-grade classrooms were chosen as strategic social contexts in which to intervene. The goals of intervention were seen to be the strenthening of the child, classroom, school, and family characteristics which might impinge on the child's adaptational status and his sense of well-being. In addition, the program was explicitly designed to involve in the intervention process not only the child and his family, but the teacher and the school as a social system as well. The program was directed by Sheldon K. Schiff, M.D. and the details of its oepration are described elsewhere (Schiff and Kellam, 1967).

The essential element of the program was a series of weekly classroom meetings involving all of the children in first-grade classrooms in intervention schools, the teacher, and a mental health staff person. As we measured the program's impact over the years, the character of the meetings changed, moving from a small group of maladapting children meeting in the same classroom where the rest of the children carried on regular work at their seats, to a total class meeting that included both the adapting and maladapting children. Later on, with additional measures of impact and study, the parents

of the children were included also in these meetings.

The weekly class meetings focussed on the child's sense of confidence in trying out and mastering the first-grade tasks expected of him. There was an effort to catalyze the development of the class's group identity in order to promote a sense of membership and accomplishment on the part of each student. Increasingly the teacher was able to run the classroom meetings and the active role of the mental health person diminished. This transfer of the leadership function from mental health person to teacher was encouraged since we had a fundamental interest in building the program into the institution of the school.

In addition to the weekly classroom meetings, there were also weekly staff meetings and, occasionally, parent meetings were held. Staff meetings were devoted to interstaff issues such as role definition, the degree to which the teachers could bank on the support of the administrative staff, and critical analysis of the clinical process that went on in classroom meetings. Difficult behavioral problems were discussed and planning for day-to-day modification of the program also occurred in staff meetings.

Since 1964 we have used the assessment of social adaptation to measure the baseline and outcome status of children in the intervention schools as compared to those in control schools. Psychiatric symptom assessments, achievement and intelligence test scores, and grades have also functioned as criteria of impact.

At the end of the first year of the program, teacher assessments revealed that children in intervention schools were less adapted and had become significantly worse than control school children. Later

experiments and long-term follow-up showed this to be due most likely to a change in standards of the intervention school teachers. For the next three years, the teachers' assessments of the social adaptational status of children in the intervention schools showed improvement over the course of first grade when compared to those of control school teachers for their students.

In regard to the other measures of outcome, at this stage in the analysis of this data there does not appear to have been measurable short-term or long-term impact on psychiatric symptoms. In third-grade follow-up of those children still in Woodlawn public schools, intervention appears to have some impact on grades, particularly in the area of language arts although we have not completed analysis of these results.[3] While achievement tests revealed a minimal impact in language, the most consistent impact appears to have been in intelligence test performance.[4]

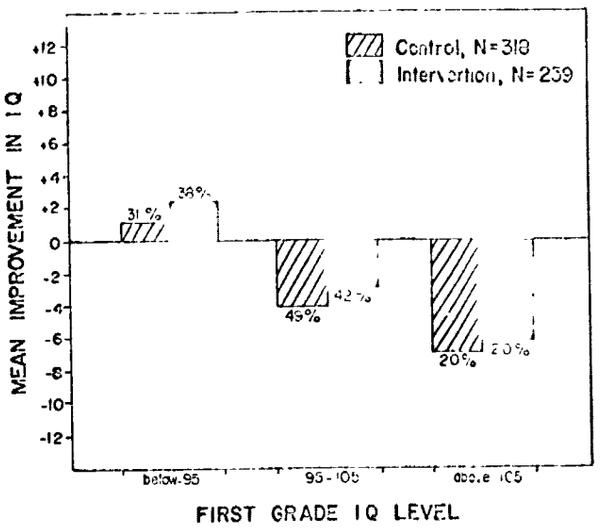
Figures 1 and 2 compare changes in IQ scores between first and third grades for the 1964-65 and 1966-67 public school children when control and experimental groups are classified according to first-grade IQ. Results for the 1965-66 population are not shown but are included in the summary comments that follow.

There was a general tendency for IQ performance to decrease between first and third grade except for children who were low performers in first grade. Keeping this in mind, we can now examine the impact of intervention. In general, children who experienced intervention showed significant benefit in IQ performance. We find that intervention children who were high performers on first-grade IQ tests showed less drop in performance than did similar control school children. Intervention children who were low performers in first grade showed greater improvement in performance than did similar control school children. It is also worth

Figure 1

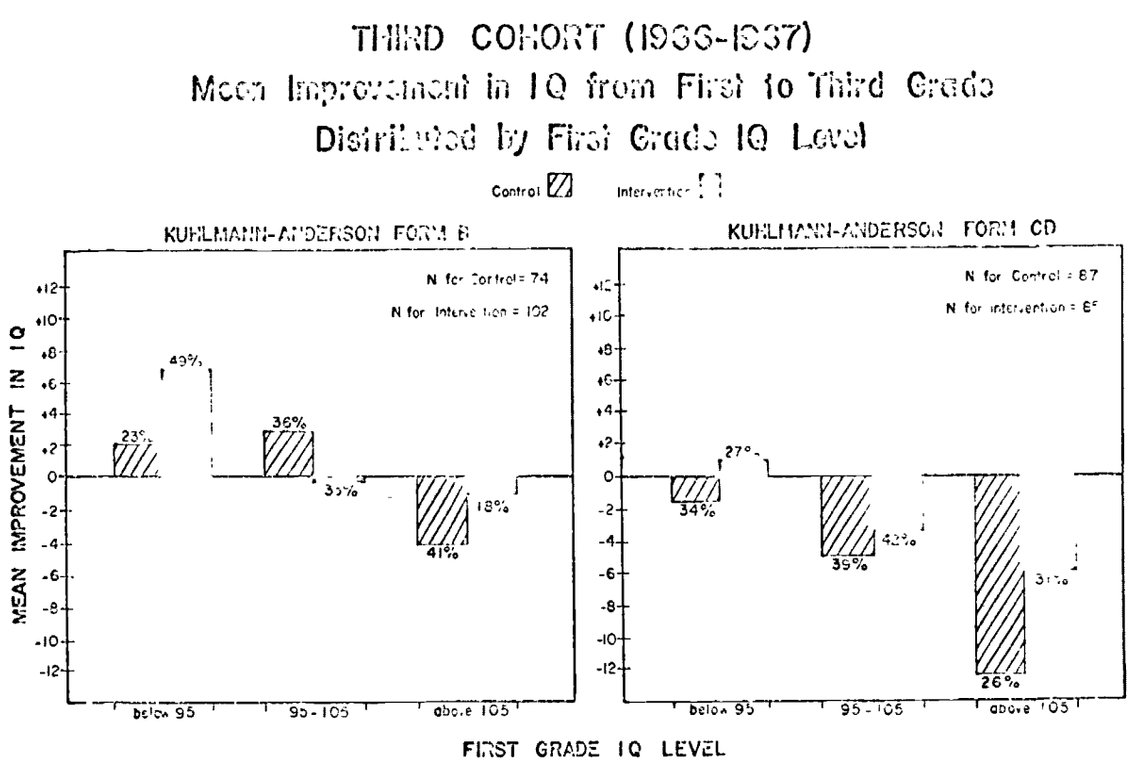
FIRST COHORT (1964-1965)

Mean Improvement in IQ from First to Third Grade Distributed by First Grade IQ Level



Percentages represent the proportion of Control or Intervention children in each IQ level

Figure 2



Percentages represent the proportion of Control or Intervention children in each IQ level

noting that the form of the test administered in third grade appears to influence whether performance gets better or worse (See Figure 2).[5]

Program changes were made periodically on the basis of the assessment and our clinical impressions. This intimate relationship of assessment/program design/evaluation/redesign should be a basic principle of community mental health and, in our view, should be equally useful as we turn our focus to the development of a new neighborhood human services system.

While measurable impact appears to have been achieved it has been modest. It is evident that we must consider other factors and be open to other kinds of intervention in support of first-grade children going through a critical period in their school career. An important source of information in this regard are the families of the first graders.

Family Life and Adaptation to School

In 1965 and 1967, extensive interviews were conducted with the mothers or mother surrogates of first-grade children that enabled us to make community-wide studies of family life.[6] The 1965 interviews were conducted by one group of interviewers and the 1967 interviews by another. In 1965, 863 interviews were conducted, a 50 percent sample of the mothers of first graders. The 1965 sample was random except for the condition that the child had been rated by his teacher early and at the end of first grade. The sample thus represents first-grade children who were in any of the Woodlawn schools throughout the 1964-65 school year. About 15 percent of the total population moved out of Woodlawn, and these children were not part of our study population. In 1967 we attempted to

contact the mothers of all the first-grade children; 1392 interviews were completed out of the total of 1691. The remaining children were not found by home visit.

By means of a detailed interview schedule, we investigated such factors as family constellation, child-rearing practices, health history of the child, the mother's health history during pregnancy, socioeconomic status of the family, and the political and social attitudes of the families.

Each interview schedule contained approximately 200 precoded questions organized into two major categories: (1) the child's relationship to his family and (2) the family's relationship to the community. In addition, six subcategories were formed, applicable to both major categories, that represent various aspects of family functions and characteristics. The relationship of the subcategories to the major categories is shown in Table 5. This organization provided a broad view of family characteristics. The six categories were taken from an eight-category grid constructed by Harold Lasswell to compare social systems in terms of human need satisfaction (1959).

Many of the factors we investigated were significantly related to the child's adaptation to school. These are summarized in Table 5 according to the categories described above. Among other things, it seems to be very important that the mother be healthy during pregnancy; that the mother not be the only adult in the household; that the mother feel hopeful about her ability to influence her child's future; and that the family have someone to whom they can turn in time of trouble. Since these are associated apparently with social adaptation--probably through complex interrelationships--they are also examples of the kinds

TABLE 5

FAMILY CHARACTERISTICS RELATED TO CHILD'S BETTER ADAPTATION TO SCHOOL*

	Child/Family Characteristics	Family/Community Characteristics
Affection	Mother was not the only adult in the household Time and attention a child received Amount of confiding a child did with the adults in the household	Length of time the family had been in their geographic location Had someone to turn to in time of trouble** Belonged to social and/or political organizations
Wealth	Space, toys, and clothes a child had	Family income above $5000 Husband in family was main earner† Main income came from source other than welfare** Families owned their homes†
Well-Being	Child was not rated symptomatic by mother	Mother seldom felt sad and blue, or nervous and tense Mother had good physical health during pregnancy**
Respect	Confidence and respect a mother felt for her child's ability and competence	(See Wealth above)
Decision-Making	Clearly defined rules set by the parents which were not overly restrictive or permissive	Parents were registered to vote in preceding election† Parents were leaders in social groups in the community
Value Orientation	Mother's 1) hopes and 2) expectations that her child would go to college Mother felt influential in her child's future	Mother felt civil rights could best be obtained by non-violent demonstration rather than by violence, or by a stay-out-of-trouble position**

*These findings are based on two-tailed t tests significant at the $p < .05$ level. Unless otherwise noted, results cited were significant for both the 1964-65 and 1966-67 interviews.

**The double asterisk indicates results based only on 1966-67 interview because question had not been asked in 1964-65.

†Results based on 1966-67 interview. Relationship did not occur on 1964-65 interview.

of concerns we feel should be within the scope of the intervention processes. They suggest further that our approach to the problem of adaptation in first grade has been indeed piecemeal, and that interventions other than those within the traditional purview of mental health seem indicated also and should be carefully considered.

Discussion

The outline for the development of a community mental health program presented in this chapter involved a strategy that places primary emphasis on establishing ongoing community sanction and participation in policy-making. Secondly, this strategy concerned the development of a community-wide system for the periodic assessment of specific subpopulations in the community, one that would yield basic information for program development. The third step was to plan an intervention program for a total population based on the assessment of both qualitative and quantitative characteristics of need. The strategy's fourth stage called for the evaluation of the program by means of periodic re-assessment of need in the total subpopulation. Finally, as the last step, the intervention program was refined in light of the kinds and quantity of impact achieved by the program.

The initial baseline assessment made on the first-grade population of Woodlawn revealed that extremely large populations of children were having difficulty mastering the job of first grade. Subsequent re-assessments showed further that many of these children, particularly if left without intervention, remained unsuccessful in school at least as far as third grade. Measures of the program's impact revealed benefit to IQ performance, little impact on third-grade achievement test scores, and short-range benefit in the teachers' assessments of the children's social adaptation to school.

A major implication of these results is that it is possible to follow the strategy we have outlined and achieve measurable impact

over several years. There is also a major significance in what was not achieved. A mental health program which enhances the intelligence test performance and general social adaptation of first-grade children is not sufficient to eliminate the problem of maladaptation among these children. In reference to the difficulties which remain, systematic studies of the correlates of social maladaptation suggested that the help of a variety of other professional disciplines is needed to deal with the overall issue of social maladaptation. In addition, we must examine broader aspects of the social system in the neighborhood and in the larger community with a view toward eliminating those aspects of our total social structure that help to generate the conditions for social adaptational failure.

In terms of human services, it seems clear that without a coordinated, broad-scale response from across the human service disciplines, these children will continue to fail at their attempts to master school in uncomfortably large numbers. Such coordination is, of course, impeded by the professional jurisdictional struggles which too often characterize any efforts to synthesize. In addition, the limitations that result from narrow training of professionals and the professional's lack of expertise in engaging with communities in their new role as policy-making partners serve to make progress toward coordination even more difficult. Nonetheless, it has become increasingly clear that the gaining and maintaining of community sanction through citizen participation at both the policy-making and operational levels of human services is absolutely critical for the success of community-wide programs.

FOOTNOTES

1. Edward H. Futterman, M.D., Sheldon K. Schiff, M.D., and Sheppard G. Kellam, M.D.

2. Mrs. Branch was in charge of this process throughout the course of these studies.

3. Parochial schools did not administer IQ tests or achievement tests in first and third grades, and their academic grades were not arithmetically comparable to those of the public schools and were therefore not included in these results. Parochial school data will be analyzed separately.

4. The sixth edition Kuhlmann-Anderson test of mental maturity (IQ) was administered to the public school first- and third-grade students in 1964-65 and 1966-67 and to the public school first-grade students in 1966-67. These tests were given by the public schools under the supervision of Blanch B. Paulsen, Director of Bureau of Pupil Personnel Services and Elmer M. Casey, Director of Evaluation and Pupil Studies Bureau of Pupil Personnel Services, The Chicago Board of Education.

5. The third-grade students in 1966-67 were given the seventh edition Kuhlmann-Anderson test of mental maturity which was administered by testers and proctors hired and supervised by the Woodlawn Mental Health Center. Half of these classes, randomly chosen, were given Form B and half were given Form CD of the Kuhlmann-Anderson test.

6. The National Opinion Research Center gave technical consultation in devising the interview schedule and was responsible, under Dr. Kellam's supervision, for conducting the interviews with the mothers in their homes. This study has profited greatly by having Paul Sheatsley and the senior staff of the National Opinion Research Center available for consultation.

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